VOL. 20

1943

TORONTO, JANUARY, 1943

THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·

Mr. Findlay

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Wyandotte General Hospital
Wyandotte, Michigan

OFFICE OF ADMINISTRATOR

December 20, 1940

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Norwood Station,
Cincinnati, Ohio.

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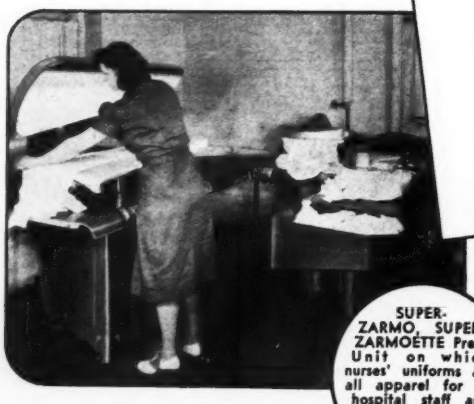
Very truly yours,

Charles E. Findlay

Charles E. Findlay, F.A.C.H.A.,
Administrator.

CEF/KM



SUPER-ZARMO, SUPER-ZARMOETTE Press Unit on which nurses' uniforms and all apparel for the hospital staff are neatly ironed at minimum cost.

ASK FOR A CANADIAN LAUNDRY ADVISER

If you have a laundry problem, the services of a Canadian Laundry Adviser are available to you . . . absolutely without cost or obligation. Write.

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"The Canadian Hospital"

Official Journal of the

Canadian Hospital Council

Vol. 20 JANUARY, 1943 No. 1

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As Precious as Jewels!

WE are illustrating these three leading Spring-Air Mattresses in this January, 1943, issue of The Canadian Hospital not because we wish to intimate that we can fill any Spring-Air orders for the present—but because we feel it is timely to emphasize the fact that, after the war, increasing numbers of hospitals will turn to Spring-Air.

Yes, more and more hospitals realize that Spring-Air Mattress comfort is a valuable ambassador of goodwill . . . at the same time their convenience pleases the nurses and aides . . . and their economical service delights the budget makers.

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'Cellona' and Colles' Fracture

A DORSAL slab made from one 6 inch 'Cellona' bandage (4 inch for children) is moulded round the radius of the base of the first metacarpal. It extends from the olecranon process to the metacarpal heads, and over the ventral surface of the radius.

(1) *'Cellona' plaster slab applied to the dorsum of the forearm.*

(2) *'Cellona' bandage applied.*

IN new fractures where swelling may occur, the dorsal slab may be secured by an open wove muslin bandage. It should be completed by the application of a further 3 inch or 4 inch 'Cellona' bandage only after the danger of swelling has passed.

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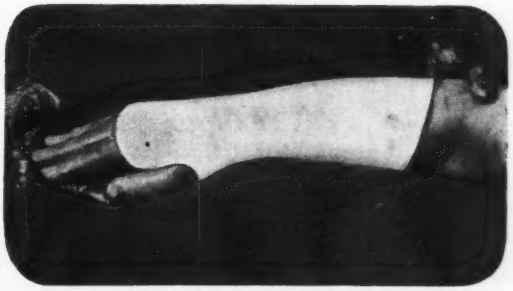

(3) *Completed forearm plaster.*

QUESTION: *I have noticed that green, leafy, and yellow vegetables are listed as excellent sources of vitamin A. Is this true of canned vegetables or only of fresh, raw products?*

ANSWER: **The vitamin A activities of these vegetables, or for that matter foods in general, are not adversely affected by canning (1). The heat treatments employed in blanching and "cooking" of canned vegetables destroy the enzymes in these vegetables; and the permanently sealed can protects the food from the air during storage and distribution. Hence, frequent consumption of green, leafy, or yellow vegetables, either fresh or canned, may be relied upon to supply important amounts of vitamin A (2).**

American Can Company, Hamilton, Ontario;
American Can Company Ltd., Vancouver, B.C.

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(1) 1938, Nutrition Abstracts and Reviews 8, 281
(2) 1939, Food and Life: Yearbook of Agriculture
U. S. Dept. Agriculture, U. S. Gov't
Printing Office, Washington, D. C.

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, January, 1943 Vol. 20 No. 1

Canadian Hospitals Invited to Participate in Wartime Health Survey

Hospital and Professional Groups to Co-operate with Medical Procurement and Assignment Board

By G. H. A.

THE serious shortage of trained manpower to meet Canada's civilian and military health needs has now reached the point where the Federal Government has authorized a searching and comprehensive survey of our entire facilities for this purpose. With whole areas without adequate, or even *any*, medical care, with hospitals unable to meet the demand for beds and unable to obtain adequate personnel, with the nursing field short of graduates, particularly of those with special training, and with inadequate recruits coming in, with the shortage of dentists still more acute, as also that of different types of technicians, and with the Active Forces and war industry wanting still more trained personnel, the time has now come when available personnel and facilities must be studied as never before to devise ways and means of meeting this situation.

With a view to enlisting the support of the hospitals in this far-reaching survey, representatives of Canadian hospitals were invited to meet the executives of the Medical Procurement and Assignment Board in Ottawa on December 9th. The hospitals were represented by Dr. George F. Stephens, President C.H.C.; Mr. J. H. Roy, executive member and President Montreal Hospital Council; Miss R. C. Wilson, Moncton, Secretary, Maritime Hospital Association; Dr. A. E. Archer, Lamont, formerly President, Alberta Hospital Association; Mr. A. J. Swanson, President, Toronto Hospital Council; Dr. G. F. Strong, Vancouver, representing Dr. A. K. Haywood and Pacific Coast hospitals; and the Canadian Hospital Council Secretary, Dr. Agnew.

The Background

The Chairman of the Board, Brigadier G. B. Chisholm, explained that it had been set up in July last because of the increasing difficulty of meeting both military and civilian needs for medical personnel. The Central Board is now made up of the heads of the medical services in the Navy, Army, Air and Pensions and of representatives of the Canadian Medical Association representing civilian, as well as military, needs, and of National Selective Service. The secretary of the Board, Dr. T. C. Routley, is now devoting almost all of his time to this undertaking. Recommendations with respect to each individual under consideration are received from similarly constituted Divisional Advisory Committees in each province.

It was soon noted, however, that the availability of many men and the coverage of the health services in any community were dependent not only upon the doctors, but upon the hospital facilities and the availability and special training of nurses, technicians, public health workers and others. No planning for future civilian needs, or the dovetailing of such with certain military needs, could be intelligently made without having a better knowledge than now exists of the available personnel and existing machinery across Canada for health care.

Accordingly the Order-in-Council authorizing the work of the Board was amended a few weeks ago at the

request of Mr. Ralston to provide for a broad study of health facilities which will probably include dentistry, nursing, public health, hospital facilities, technical assistance, medical education, industrial medicine and other related fields.

The Honourable Mr. Ralston, who honoured the meeting with his presence for a time, expressed his satisfaction with what had been accomplished to date by the Board and stated that he was wholeheartedly in accord with the proposal for a National Survey of our health resources. He stressed that both military and civilian needs must be carefully considered and that there should be close integration with National Selective Service. He prefers the conception of gears "meshing together" rather than the overworked term "co-operation".

The Proposal

The proposal, as outlined by Dr. T. C. Routley, is that the hospitals of Canada, through the provincial and other units of the Canadian Hospital Council, should undertake that part of the study which has to do with hospital personnel and facilities. In each province there would thus be committees representative of the medical profession, the hospitals, the dentists, the nurses, the public health organization and other groups, all studying their local situations. Some of these studies would be closely inter-related, the hospital survey, for instance, being closely linked with that of medical, nursing and technical personnel. Accordingly, it is proposed that in each military district, corresponding generally to provincial boundaries or to portions of provinces, there be provided from the Armed Forces a full-time secretary who would act as liaison officer between the various committees in that district or province. He will probably be a well-informed enlisted medical officer. It may also be possible to have some of the clerical work done by members of the C.W.A.C. and of the R.C.A.F. (W.D.).

Brigadier Chisholm pointed out that in view of present and anticipated conditions, *a survey of the nature proposed is inevitable and it would seem better that it be done by the professions themselves rather than by some other agency outside the professions.*

Various aspects of the proposal were discussed at some length. Dr. Stephens pointed out that the Canadian Hospital Council is a federation of provincial and regional associations and has no power in itself to do other than recommend to its component parts that they undertake a certain piece of work. He was of the opinion that the hospital people of Canada would be willing to do their part in any such survey.

In explaining the extent and scope of the hospital survey, the Chairman stated: "It is hoped by the Board that the sum total of the survey will present a complete inventory of our manpower and womanpower in the health services, show where they are, bring out clearly all of the needs and then finally make recommendations by which the best possible use may be made of our resources."

It was agreed that the hospital associations might be invited to participate in a two-fold study:

I. A fact-finding survey to be completed by March 31st, 1943, with recommendations, and

II. A study of post-war objectives involving hospitals, to be done at a later date.

Scope of Study

It was agreed that the survey which the hospitals were being invited to make might consider:

(a) A study of the best means of ensuring that the available supply of doctors, nurses, technicians, dietitians, orderlies, engineers, etc., be retained, released or allocated to meet the demands of:

i. Active Forces;
ii. Civilian Hospitals;
iii. War Industries.

(b) Consider possible needs of civilian hospitals (personnel, beds and equipment) in case of:

i. Raid, sabotage or industrial disaster;
ii. Wounded soldiers evacuated to Canada by ship or cargo plane; ("b i" is closely linked with A.R.P.)

(c) Training of new personnel:

i. Technicians — pathology, bacteriology and x-ray (for civilian or military hospital employment);
ii. Nurse aides and other subsidiary workers;
iii. Retired nurses.

(d) Extent and conditions under which enlisted doctors and nurses could be utilized in civilian hospitals:

(e) Extent to which military patients could be cared for in civilian hospitals.

(f) The survey might go further and consider a state of *dire emergency* with all personnel and facilities regimented to provide maximum national effort. In such a contingency the civilian hospitals might need to have ready a plan for "skeleton operation", pooling all hospital resources in a community and eliminating every bit of unnecessary service or duplication. This might be considered later.

(It is realized that there are many practical difficulties about any drastic plan which would have worthwhile practical recommendations, but such might well be considered.)

(g) *Plant and Equipment*

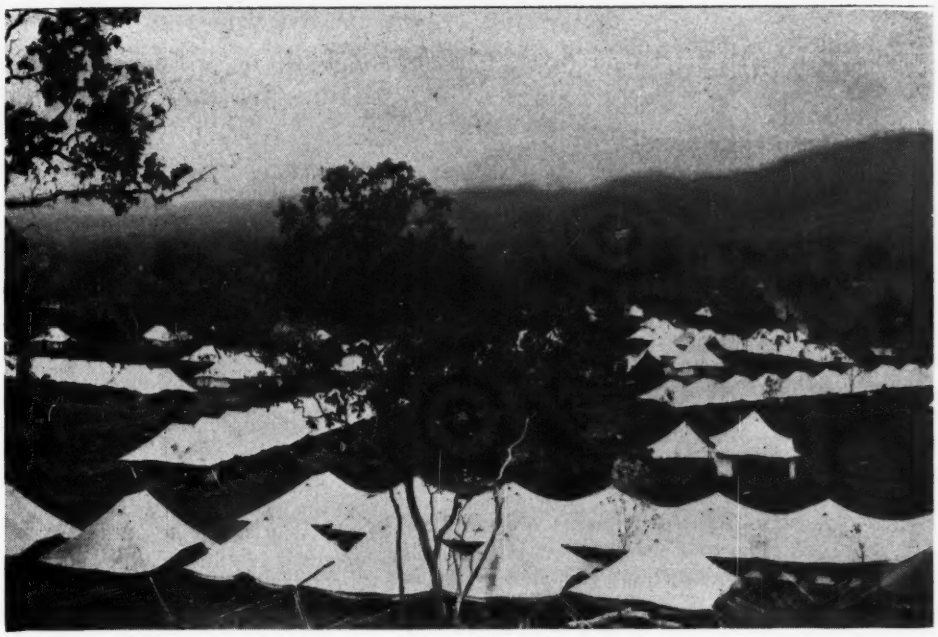
i. Making better utilization of present equipment and space;
ii. Assurance that available new equipment and material be allocated to best national advantage.
iii. Possible organization of all voluntary and municipal hospitals in an area on a co-ordinated basis of function (as in Great Britain);
iv. Joint use of certain hospital facilities by military and civilian staffs;
v. Possible setting up of diagnostic and treatment centres for certain areas.

(h) *Financial Assistance*

i. For special equipment or extensive alterations;
ii. For loss of revenue due to possible reallocation of services if situation becomes more serious.

Post War Problems

On completion of this urgently-needed study, it was suggested that profitable discussions might take place relative to the betterment of our whole hospital organization (or lack of such) as a hospital contribu-



Military Hospital Area in New Guinea

Issued by Dept. of Information, Commonwealth of Australia.

tion towards a better and more efficient post-war society.

It was agreed that the first step should be an invitation to the provincial and regional associations to undertake this important study. If agreeable, provincial and local committees would be set up and contact made with the officer delegated to act as co-ordinator of the various district committees. Contact would also be made with the Divisional Medical Procurement and Assignment Board in each province, functioning since last July with respect to medical men.

Much of the factual information will need to be obtained by questionnaire. As a guide to the associations the Executive of the Canadian Hospital Council has prepared a suggested outline for such questionnaire which will be sent shortly to the associations. Two years ago the hospitals kindly supplied data giving available space in case of emergency, but that information, valuable at the time, has probably become obsolete.

Hospital authorities are requested to co-operate to the fullest extent in this study. We hope that it will never be necessary for hospitals to make drastic adjustments in their personnel and work undertaken. But it is our national duty to help the war effort in every way possible and to be prepared with a plan for carrying on should an extreme contingency arise.

Compensation Board Payments Raised to Ontario Hospitals

In December the Workmen's Compensation Board of Ontario agreed to raise the payments to hospitals on a temporary basis pending an intensive study of hospital costs. This decision followed representations by the Ontario Hospital Association Commitee on Legislation, which urged that higher rates be paid in view of the increased costs in providing hospitalization.

Following the principle that payment to hospitals should be graded to take into consideration the greater facilities of most larger hospitals and the varying costs in different centres, the following rates were authorized, to go into effect almost immediately:

For hospitals of 501 beds and up, $4.25 per day plus extras.
For hospitals of 301 to 500 beds, $4.00 per day plus extras.
For hospitals of 201 to 300 beds, $3.75 per day plus extras.
For hospitals of 101 to 200 beds, $3.50 per day plus extras.
For hospitals of 100 beds and less, $3.25 per day plus extras.

The Workmen's Compensation Board also agreed at the same time to enter, with the Association, into a study of costs in the different sized hospitals of the province, in order that adequate rates be provided for all hospitals.

An intensive study of costs has already been made in two or three of the largest hospitals in Ontario and the above suggested rates for that group of hospitals have been set to partially meet costs, as shown by that study. The Committee on Legislation of the Ontario Hospital Association has agreed to this temporary schedule of rates on the distinct understanding that a careful study be made as quickly as possible of costs in all grades of hospitals in the province, so that a complete revision may be made within six months.

Hospitals Close Down for Lack of Personnel

Lack of trained personnel, particularly of doctors, has forced several more Canadian hospitals to close down. Officials of the Alberta Government Department of Health have announced that three hospitals in the province have been compelled to take this step, and it is feared that others may have to follow suit.

The hospital at Zeballos, B.C., has been closed since October.

Provincial Engineer Serves Serious Warning on Hospitals

Hospitals Must Help to Train Own Engineers

By VERNON PEARSON,
Mechanical Superintendent, Dept. of Public Works, Alberta

AMONG the many annoyances today is the difficulty of securing the services of men with Stationary Engineers' certificates. In this province, as long as I can remember, there has never been a surplus of competent engineers. The present shortage of men has been foreseen for some considerable time, and while it is true that the war has focused our attention on this shortage, the war is not responsible for it.

The great majority of the men who are engaged in this class of work are past middle age. The percentage of young men is very small. A careful examination will also disclose the fact that most of these elderly men received their early training in the Old Countries. A large number are from the British Isles, and there is a sprinkling of men from Scandinavia, Holland and Germany. Most of them came to Canada betwen 20 and 30 years ago. Since 1920, however, this source of supply has dried up and immigration since that time has been almost at a standstill.

Those of us who are charged with the administration of the Boilers Act in this province have known for some time that a shortage of engineers was inevitable, because the 3rd Class engineer of today is the 2nd Class Engineer of tomorrow and the 2nd Class Engineer of today is the 1st Class Engineer of tomorrow. Therefore, it is not difficult to look down the line and see what the future holds. Under existing conditions it will take a smart young man ten years to acquire a 2nd Class Engineer's certificate. The only method open to him is to move around from one job to another until he has acquired sufficient knowledge and experience to pass the necessary examination. Unfortunately, when he utltimately secures his certificate, the positions open to him are none too attractive. This period of time is too long. This is borne out by the fact that men who have received an early and complete training have been able to secure 1st Class Certificates by the time they were 30 years of age. The fault lies in the fact that no interest has been shown either by hospitals or industrial concerns in the question of training men to a point where they are capable of filling vacancies in their organizations.

Address, 1942 Convention, Alberta Hospital Association.

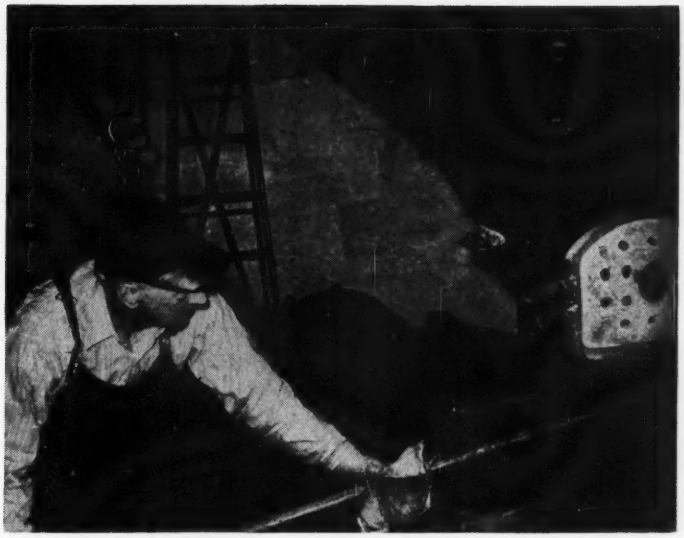
Courtesy Mr. Arthur Parker, Toronto Western Hospital

Why not Train Engineers also?

For a long time the training of nurses has been taken care of by schools of nursing run by the larger hospitals, simply because the authorities realize that it would be quite impossible to maintain nursing staffs in any other way. If the hospitals neglected their schools of nursing and took the attitude that they would get nurses somehow from somewhere when they needed them, it would not be long before they would find themselves in serious difficulties. This shortsighted attitude, however, has prevailed towards the training of engineers and other skilled men required in hospital and other plants.

The question which now presents itself is, where are we going to get suitable men in the future? Personally, I do not believe that we can look to the Old Countries for them, nor do I believe that there will be any abundance of trained men after the war is over.

We read a great deal about girls and boys who a few weeks ago were



engaged in the usual occupations, being welders and machine operators in war industries. I have also read that one can learn to play the piano like Paderewski in ten easy lessons, but we are not going to produce any engineers in this way. It is true that a vast majority of people engaged in war industries are new to the work. However, they have received a short training as specialists in a limited field, and behind them there is a staff of men who are highly trained, and in most cases have had a very long experience in engineering work. The hospital engineer has a wide range of duties. Educational authorities in Alberta have made it possible for men in engineering work to acquire knowledge, but plant owners have not made it possible for them to acquire skill and experience. Experience has taught me that the ordinary power plant is regarded by its owners as a necessary evil and any expense incurred in it is frowned upon as a nuisance.

The ordinary engineering staff in most hospitals is kept at the irreducible minimum and no one is employed there unless he can give full value for the money he receives. That this policy is a shortsighted one has been demonstrated on every hand. The shortage of men will become more acute because nothing has been done for the past 20 years towards filling the inevitable gaps in organizations and the older hands are gradually disappearing from the scene.

It is quite obvious that *the only way to get men for our engineering activities will be to train them ourselves.* Most large hospitals are very well equipped for this purpose. In every line, engineering, plumbing and electrical work, they have a wide variety of equipment and opportunities for training engineers and mechanics are excellent. In order to provide the necessary men for future requirements, *it will become necessary to put young men into plants as helpers* and every facility and encouragement will have to be given to them to become competent.

Scientific Emergency Rations Developed for Naval Use

AFTER seven months of research a group of Canadian nutrition workers have announced a new method of supplying concentrated food for the use of sailors and others forced to spend long days and nights on rafts or in lifeboats.

The research involved not only the selection of specially prepared foods but the development of special containers as well. The kit, about the size of a lady's overnight bag, is covered with a salt-water resistant material. The water can holds 16 ounces of water and is also salt-water resisting. There is a chocolate ration bar which will stand considerable increase in temperature without melting. There is also a chocolate tablet ration, which is 70 per cent whole milk. A small food container, but little larger than a sardine tin, holds 12 of these tablets, 12 biscuits of concentrated food and two bars of chocolate.

Into each main ration box goes eight tins of water, eight tins of food and eight packets of extra ration food in the form of malted milk tablets. Chewing gum is supplied also.

This kit, which weighs about 17 pounds and costs $7.50, is designed to feed one man for eight days. The small food container, when emptied, becomes a drinking cup with ounce and 2-ounce measurements shown.

In order to make this food of the desired concentration, to provide a proper nutritional balance, to ensure that it would not induce thirst, to achieve a palatable taste and to so process the food that it could be sterilized, required months of intensive laboratory experimentation.

The men responsible for this fine achievement, which may be responsible for saving many lives in the near future are, Surgeon-Commander Charles H. Best, professor of physiology at the University of Toronto; Lieut. James Campbell, a young Scotsman working at the University of Toronto, who is the bio-chemist and head of the nutritional section of the Canadian Government's Medical Research Unit; and W. G. E. Eggleton, formerly professor of bio-chemistry at Lester Institute in Shanghai, now in Toronto.

Others who assisted are Surgeon-Lieut. J. E. de Belle, formerly superintendent of the Children's Memorial Hospital in Montreal; Lieut. R. W. Millard, technical expert of naval stores, Vancouver, and Surgeon-Captain A. McCallum, V.D., Medical Director General, R.C.N.

They were also given considerable assistance by various chocolate manufacturers and others interested in this development.

It is planned to place four of these kits on each 10-man raft and eight on each 20-man raft. Although the rations are lashed in place, the container is designed to float.

National Health Insurance and the Voluntary Hospitals

By the REV. F. J. BRENNAN,
London, Ont.

THE "Principles of Health Insurance As It Affects Hospitals" prepared by the Canadian Hospital Council is the tentative reply of the hospitals of Canada to a request for a statement of the basis of hospital participation in a national health insurance propramme.[1] The discussion of these recommendations must be without prejudice to basic views of the fundamental principles underlying the whole question of governmental activity in the field to which they are addressed. Government has a measure of responsibility in the curative and preventive constituencies of health care. When this is carried to the advanced position of a compulsory national health insurance undertaking, approach is made to the danger area of collision between increasing bureaucratic control of health machinery and the right of individuals and groups to contribute to the public welfare through private effort and to practise the social virtues of philanthropy and charity.

Recognition

The proposed national health insurance plan, as we believe it to be conceived by the Federal Advisory Committee and as emphasized in the Canadian Hospital Council "Principles",[2] fully recognizes the place which the non-profit voluntary hospitals occupy in the hospital system of Canada. The declared intention of the Drafting Committee of utilizing their facilities in operating the Plan is a further step in the useful co-operation of governmental departments with voluntary agencies. It will prove a protection due to a great institution which, in its national dimensions, represents a vast asset of trained personnel and an immense investment. It will put the Plan more fully at the service of its beneficiaries and will safeguard the interests of a large section of the medical and nursing professions. Official statistics show clearly that the policy of those drafting the Plan to operate through the existing approved hospitals will avoid the huge expenditures of public money as capital investment to meet the increased demands for hospital service.

Representation

Participation in the National Plan should call for adequate representation of the non-profit hospitals on all directive and administrative sections of the operating organization. This is essential to the satisfactory discharge of the duties confided to the hospitals by the Plan and to the carrying out of the contracts with the subscribing patients. As one of the distributing agencies of the benefits of the Plan, the hospital becomes an important voice of the customer and ultimate consumer to the Plan management. Voluntary hospitals have problems peculiarly their own, the solution of which can be secured most readily and satisfactorily through the medium of adequate representation.

This representation will contribute to the success of the Plan in two important ways. It will assure autonomy of internal control of hospital management within the framework of safeguards provided by government regulations. This control is essential to the maintenance of the proper measure of freedom which the hospital should enjoy, the spirit of initiative and the sense of responsibility. Secondly, it will keep open an avenue of easy discussion of the questions dealing with the character and extent of service which can be given efficiently under the Plan and the correlative question of adequate remuneration for services rendered. In the long run, it will not be helpful to overburden the health agency with too heavy service obligations, or to admit state paternalism with the pampering of patients through luxury treatment. Nor will it be wise to impose added tax burdens on citizens who, in any event, contribute twice to the financial support of the scheme, once as taxpayers supplying the government's share and again as contributors paying employers' or employees' fees. That scheme will be most successful which most effectively emphasizes the obligation of the hospital to do its part in bringing the patient back to normal health with despatch and provides equitable compensation under a Plan, actuarily sound, for the treatment given.

Beneficiaries

The contemplated care of the economically *indigent* under the proposed Plan cannot but receive full approval. It is to be hoped that a practical and easily operated method will be devised to place responsibility for this class of patient where it belongs. The hospitals should be relieved of the nuisance and loss occasioned by the evasion of this responsibility by public bodies and officials.

As the scope of the Plan ranges upwards through the medically indigent group towards the class of those who are competent to make

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Father Brennan is Chaplain to the Ontario Conference, Catholic Hospital Association. This address was delivered at the convention of the Ontario Hospital Association in October.

[1]*See The Canadian Hospital, October, 1942.*

[2]*Principle 6. That, except by special arrangement, the hospitals eligible to receive insurance patients be those recognized by the provincial government as "public" hospitals; i.e., either non-profit voluntary hospitals (lay or religious) or municipally-owned hospitals.*

Principle 7. That voluntary non-profit hospitals be utilized provided they conform to the standards of service stipulated by the Commission or other directing body.

Courtesy Australian Department of Information

A corporal in charge of a waggon loading post somewhere in the New Guinea jungle manages a first aid post for troops passing through the area.

provision against all the direct and indirect costs of illness, the door is opened to controversy. Measures for protection by prudent prevision through compulsory pre-payment plans must not destroy that sense of personal responsibility which combines with freedom of action to make for virile citizenship. The surrender of personal responsibility to the paternalism of government is hurtful to national morale. The experience of relief undertakings in the days of depression must not be forgotten.

The safeguarding of the right of the patient to his choice of hospital is part of a larger feature of the "Principles" which must not be allowed to disappear from the Plan.[3]

The superiority of human personality to material possessions does not permit the consideration of health care to be put on the same basis as that of the protection of property. Medical, nursing and hospital services, in respect of patient choice, are not on the same level as police and fire protection. Those who lose sight of the appropriate distinctions are, consciously or otherwise, moving in the direction of stateism which makes their struggle for the democratic freedoms tragically absurd.

[3]*Principle 17. That patients have the right of selection of hospital, provided the patient comes within the categories accepted by that hospital.*

Opportuneness

The observed result of the operation of voluntary health insurance plans is an increased demand for the services offered. War conditions have created difficult problems in every group involved in the national compulsory Plan. It may be reasonably anticipated that a premature inauguration of the proposed scheme would meet with a scarcity of personnel and a shortage of material which would make extremely difficult the fulfillment of the contract with the subscribing patient.

This discussion of the proposed National Health Insurance Plan in respect of the voluntary hospital, does not pretend to deal with the fundamental merits or demerits of Government - sponsored, compulsory schemes as compared with those of privately directed, voluntary undertakings. It restricts itself to the consideration of a few aspects of hospital participation as dealt with in the "Principles" adopted by our hospital organization in so far as they affect voluntary hospitals.

Proposal to Conscript Health Personnel in Canada

A committee of the Dominion Council of Health, meeting recently in Winnipeg, adopted a resolution calling for the conscription of all employees, temporary or permanent, of all public health services in Canada, the freezing of employees in their positions and the wearing of uniforms. It also recommended that the Canadian Medical Procurement and Assignment Board be given statutory power to transfer public health workers to "wherever their services are most needed".

Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, was chairman of the meeting.

Canadian Naval Surgeon Reported Missing

Surgeon-Lieut. Jacques de Lorimier Bourgeois, R.C.N.V.R., has been reported missing and presumed killed in action. Lieut. Bourgeois enlisted in the Canadian Navy in December, 1940, and was later loaned to the Royal Navy.

His father, Dr. B. G. Bourgeois is surgeon-in-chief of Notre Dame Hospital in Montreal.

Three Proposals for Social Advancement Offered to British People

Revision of Medical Services Recommended

By G. H. A.

WHAT amazes most of us when we think of the prodigious effort which Britain is making to win the war, is that anyone in that little island has any energy or time left to contemplate post-war social reconstruction. Yet within the space of a few months three reports from three different bodies have proposed changes far beyond anything considered on this continent.

These reports, although prepared by three different organizations, show a remarkable similarity in thought, and, representative as they are of responsible groups, they do give some indication of the trend of thought among a people who show an amazing combination of conservatism and radical progress.

The three reports in question are the report of the British Medical Planning Commission, the recommendations of PEP (Political and Economic Planning), and the so-called and widely-publicized Beveridge Report.

British Medical Planning Commission Report

The British Medical Association Commission is made up of seventy-five members representing all aspects of medical work. This Committee began its sessions in May, 1941, and presented its approved interim report a year later (*B.M. Journal*, June 20, 1942).

They found that "there has been no comprehensive national health policy. Distribution of functions among agencies of local and national government has been haphazard". There are too many such agencies and too little collaboration with voluntary bodies, including the medical profession. The benefits of national health insurance have been limited to wage-earners, have excluded their dependents and have not provided for consultant, specialist or hospital services. In British medical work as a whole the general practitioner has been compelled to work in isolation. There has been a lack of intimate relation between preventive and curative services, and the voluntary and governmental hospitals have not been brought into close enough collaboration.

The majority of the Commission favours a continuation and extension of the present national health insurance scheme. It should be made to cover approximately 90 per cent of the population. Medical practice should be conducted through a system of local health centres affiliated with larger units and with hospitals. Group practice is desirable.

The voluntary and the governmental hospital systems should be brought together. The unit of hospital administration should be regional. The regional council or authority should direct and control the general activities of the different hospitals although it should not interfere with their internal organization.

There is lack of agreement as to whether the regional hospital councils should have executive or only advisory authority. It is suggested also that a limited number of hospital staff members should be full-time salaried men with no private practice; a larger number would be on full salary with certain practice permitted within the hospital; a still larger group would be on part-time salary with the privilege of practicing within or outside the hospital. There would be set up a central authority to be concerned solely with all the civilian medical and auxiliary medical services.

Model Health Centre

This report recommends the setting up of health centres as stated above. These would be part of the regional authority's medical service, the building and equipment being provided or approved by that authority. General practitioners would attend at the centre at arranged hours. There they would be consulted by their patients. They would also undertake obstetrical, ante-natal and post-natal work, do infant and child welfare work, conduct school medical services, arrange consultations with specialists and work at the local hospitals. The work of the centre would be preventive and educational as well as curative.

The centre would have access to an x-ray and a pathological service, either at the centre or elsewhere. There would be a pharmacy and a communal arrangement for records and secretarial work. The centre would provide consulting rooms for each doctor, waiting rooms, treatment rooms and a minor operating room. The average centre would provide space for ten or twelve doctors in cities and smaller numbers in mixed areas.

The citizen would be free to choose his health centre within a reasonable distance and select a doctor from those working at the centre. Each doctor would have his own list of persons (capitation basis). They would carry on very much as they do now, excepting from the medical centre. Periods for holidays and for compulsory regular post-graduate study would be provided. A certain number of assistants would be appointed *to the various centres, not to the individual senior doctor.*

Doctors would be paid (a) a basic salary, based upon qualifications and length of service; (b) a capitation fee according to the number of persons or families on his list; (c) other fees or salaries for work done apart from the insurance plan.

Minority Report

A minority of the Commission recommended a whole-time state medical service in which all physicians would be on full-time salary from the government.

The majority report was discussed at the September meeting of the

At the Editor's Ski-Lodge, Glenville, Ont.

British Medical Association, and its main recommendations were approved by a small majority.

P E P

The second British report of interest is that put out by P E P (Political and Economic Planning), issued in July by "Planning", London. This organization has issued very interesting studies for several years now, and in this latest report proposes that health and social services as well as other "income-maintenance" services shall be unified from the administrative viewpoint under a Ministry of Social Security.

The publication proposes that under the proposed Ministry would fall unemployment insurance, now under Labour; old age pensions, now under Pensions; much of the work of the Ministry of Health, Workmen's Compensation Board and Burial Insurance. The purpose would be to prevent confusion, overlapping, gaps and unnecessary administrative costs.

With respect to medical services a health-centre-group-practice scheme, similar to that of the B.M.A. proposal, is recommended. However, rather than extend the present National Health Insurance Scheme, it urges a unified medical service which would not exclude 10 or 15 per cent of the total population from the panel medical services, as would the B.M.A. plan.

Beveridge Report

Tremendous publicity has been given in Canada as elsewhere to the report of the British Government Committee set up some 18 months ago to work out a plan for dealing with post-war problems. This 80,000 word report was prepared by an interdepartmental committee under the chairmanship of Sir William Beveridge, although the actual report is that of the chairman rather than of the Committee.

In preparing the material the Committee received evidence from more than a hundred organizations and individuals and covered a wide range of social security and health problems.

There are two main objectives in the report—one, the introduction of a comprehensive system of social insurance, including health insurance, and the other the establishment of a national income minimum, below which none would fall.

The Beveridge Report does not so much emphasize medical care as it does other aspects of social security. All classes of Social Security benefits would come under one head, there being but a single collection for such benefits as unemployment insurance, disabilty, funeral benefits, etc.

Many groups of individuals not covered by present social insurance would be included. There would be marriage grants, maternity grants and widowhood, separation and retirement pensions. There is even a proposal, although a suggestion only, that it might be advantageous to convert the business of industrial insurance into a public service. There would be dependents', guardians' and children's allowances or benefits. The present limited medical service would be extended to include comprehensive medical care for every member of the family. Free hospital care would be provided, as also a measure of dental, nursing and convalescent care.

The major portion of the heavy cost of such an all-inclusive plan would be raised by a combination of contributions from the insured persons, the employers and the Exchequer. Contributions from individuals would be grouped according to age, sex and income.

It is estimated that the total expenditure on all items would be £697,000,000 in 1945, rising to £858,000,000 in 1965. This would not all be new expenditure, as existing

(Concluded on page 42)

Business Principles in Hospital Management

By W. H. MOFFATT, Accountant,
Provincial Public Health Department, Regina.

WHILE it is properly appreciated that the primary object of hospitals is to care for the sick, it also must be recognized that business principles must govern their management, if standards are to be maintained, economy promoted and efficiency fostered.

The hospital of to-day is the workshop of modern medical science and is a far cry from the hospitals of the past which were in reality boarding houses for the sick. Doctors at that time depended on the eye and ear for their diagnosis; to-day these have been supplemented by laboratory procedures which medical science proved to be of invaluable aid. Diagnosis has thus been removed from the "hit and miss" method of the past to the present period of reasonable accuracy.

Efficiency in hospital care and efficiency in business methods go hand in hand. You cannot expect to provide expert hospital care unless your financial policies are managed so as to provide the equipment and supplies which are necessary for up-to-date hospital treatment.

Corresponding with these changes in the medical field, there have also been changes in the financial outlook this last ten years, and it is time that all hospitals became aware of these changes and adapted themselves accordingly.

Hospitals have apparently passed into a new financial era. The deficits of hospitals have lost their potency to obtain additional income in soliciting the public for funds. Taxpayers and municipal bodies now look with disfavour upon huge hospital deficits. Deficits, therefore, are to be avoided, and a real effort made to keep expense within income.

Accurate, concise guiding information is the theme of modern business methods. This, applied to your hospital, means the keeping of proper financial and statistical records. A hospital trying to carry on without these basic records is like a ship without a compass.

The necessary procedures may be considered under three major headings:

(1) An accounting system showing the profit and loss for a given period;
(2) A cost system showing your main departmental costs, as these are an indication of your efficiency and will also serve as a guide to your charges for extras.
(3) A budget showing the past year's operations, with an attempt to forecast the revenue and control the expenditures.

With the cost of hospital care increasing, how may hospital budgets be balanced?

Increase the volume of business being done

This applies mainly to those hospitals who are operating with a low bed occupancy, as an increase in the number of patients cared for would increase the revenue with very little increase in hospital costs.

This might be brought about through a proper public relations programme to inform the public of the work being done in hospitals and the need for public support, or, as Alden B. Mills states in his recent book entitled *Hospital Public Relations:* "If a hospital provides kindly, thoughtful and intelligent care, it should take definite steps to inform the public of this fact."

Increase the hospital revenue by improving collections from patients

The admitting department is the most important factor in the hospital financial set-up and 95 per cent of the collection problems can be solved there by the application of proper business methods.

Show the utmost in courtesy and politeness, but at the same time maintain the fundamental admission rules that are in force with absolute firmness. It is always easier to obtain payment if business-like procedures are in effect. Rates and services should be fully explained.

It is a good idea, if possible, to let the patient know, with the help of the doctor, how long the hospital stay will be. The cost of the service that the patient is about to receive can then be estimated.

Arrangements regarding the hospital bill should be made at the time of admission and in most cases it is advisable to obtain a deposit to cover the first week's charges with the understanding that the balance will be paid at the time of discharge. Take time to explain the necessity for this rule, that is, the advantage of getting a part of the hospital bill paid and the advisability of not disturbing the patient or family during the difficult few days following operative procedures.

Full and complete answers to the questions asked on the admission form should be obtained. This is important as much of the success or failure of the collection efforts depends upon the thoroughness and accuracy of the information received. It is also by this information that a patient's account can be classified so that the necessary action can be taken to collect the account.

If an increase in the hospital's revenues cannot be brought about by the two above-mentioned methods, then the only alternative is to increase the basic rates.

To play fair with the Wartime Prices and Trade Board this should be done only if (a) your hospital is operating at a loss; (b) all possible economies have been effected and (c) your cost accounting figures indicate that your hospital services are costing more than the current rates being charged for such.

In conclusion I am sure you will agree that the increasing demands on hospital service call for the exercise of every possible measure which will make the hospital dollar obtain maximum results consistent with good service, and this can only be brought about by the constant application of sound business principles.

Address, 1942 Convention, Saskatchewan Hospital Association.

Nutrition in a War Industry

Mrs. V. P. IGNATIEFF, Dietitian,
General Engineering Co., Ltd., Toronto

THERE are three principles which should be practised in nutrition in war industry:

1. Attractive meals should be offered to the workers.

2. These meals should be produced most economically so that they may be offered at a price which the workers will pay.

3. The principles of nutrition should form the basis on which these meals are arranged and produced.

In a war industry the immediate aim of all effort is the production of war materials. The provision of a canteen or restaurant is a necessary part of this effort. These meals assist production in combatting fatigue and discouraging the consumption of poor lunches. Rest period refreshment increases the efficiency of workers, and it is believed that the meals improve the health of workers whose diet is not up to standard.

First Objective—Attractive Meals

Organization

In our plant the canteen is organized as a service for the workers. The workers may carry their own lunches and our success is measured by the proportion of the workers who eat the meals.

The department is organized and directed with individual work plans for all workers. The staff works on the preparation of the meal for each shift, so that each meal is freshly prepared. The dietitian follows the serving of the meal to check the appearance and taste of the food as it passes to the customers. Finally, three choices of three-course meals (two hot and one salad plate) are offered to the workers at 25 or 35 cents per meal.

Studies of the Likes of the Workers

All servers report daily the response of the plant workers to different foods. The supervisor of service relays these ideas to the dietitian.

Examples:

Salads: In serving salads a preference is found for cooked vegetables. Therefore, we cook the vegetables for salads a short time and include raw vegetables in a mixture. This study of the likes of the workers has increased the salad meals up to 40 per cent. of the total number of meals. The workers demand fruit salads daily.

Desserts: Apples and other fresh fruit offered as an extra variety of desserts are now demanded by customers.

Beverages: Milk consumption was increased by including chocolate milk and buttermilk in the varieties. Coffee served during rest periods was made with 25 per cent. milk and preferred by the workers.

Education

When consistently attractive meals are offered to workers, their confidence grows, and they educate one another to try new foods. This enables the canteen to introduce more variety in the meals.

Second Objective—Low Cost Meals

Organization

The buying, menu planning and the use of left-overs is personally directed by the head dietitian and the assistant dietitian. As the percentage of waste determines the cost of the meal more than the original cost of the materials, the control of waste is emphasized. We purchase the best quality of meat—not a fancy quality. We arrange our menus to use that meat in dishes which are most attractive but, to avoid waste, we plan the menus to use the meat for the most economical butchering, i.e., that there shall be no waste. Each day, each meal, there are left-overs. If those left-overs are used immediately, they yield more attractive dishes. They require less labour and fewer additional ingredients to be prepared for further use. Therefore, an intelligent control of the waste and left-overs from each meal can control the cost of the meals. We have develop-

Given at the Ontario Hospital Association Convention, Toronto, October 1942.

Winners in Company Beauty Contest Demonstrate Results of Wholesome Food.

ed in our department a keen consciousness of waste in all our workers.

Education

The company operates the canteen. As this factor assures the workers that there is no profit made on the meal offered, they become confident that the meals are the lowest price obtainable. They realize that they are receiving the most value possible for the money they pay.

Third Objective—Scientific Nutrition

Organization

This includes daily teaching in methods of food preparation. *Soups* of highest nutritive value include fresh meat bones, vegetable water and fresh vegetables as far as possible. *Vegetables* are steamed to preserve minerals and vitamins. *Fruit* is served and is much in demand as a dessert. Apples are very popular. We use domestic quality but have educated customers to buy by taste rather than appearance. *Milk* consumption is very high. We allow milk to be substituted for any article on the menu. Twenty-five per cent. of our customers drink milk as a beverage with their meals, 20 per cent. drink coffee and 55 per cent. tea. Incidentally, 60 per cent. eat brown bread and only 40 per cent. the "Canada Approved" white bread.

Education

Education to develop the attitude of proper healthy eating is achieved through the personnel department and the medical department. The public health nurses of the medical department are interested in the general welfare of the workers and assist greatly in this education on nutrition habits.

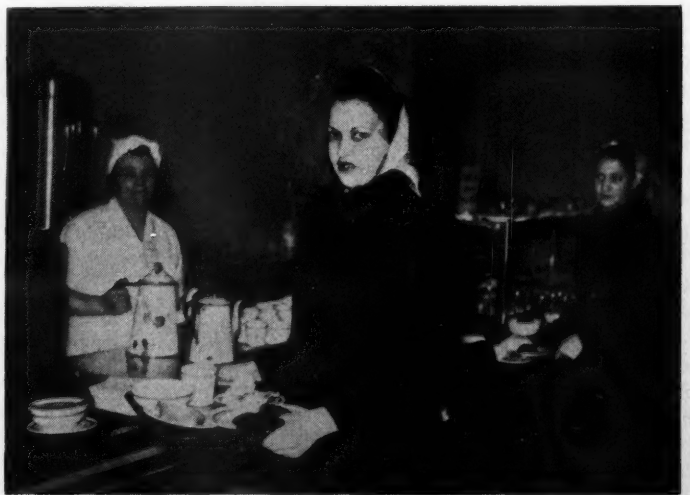
All our problems, such as night meals, choice of salad, etc., have been helped by the education carried on in these two departments. The personnel workers and the nurses concentrated their efforts on the night shift. They developed the attitude in the workers that one must eat what one ought to eat and not what one felt like eating. The workers asked for sandwiches. We felt that if we served sandwiches they would all eat a sandwich and drink coffee or a soft drink. We never offered any sandwiches and gradually the education was successful. The workers agree that they feel better and work better if they eat a proper dinner during their night shift. We are serving a full dinner to the same proportion of the workers at night as we serve in the day. We offered only hot dinners at night but salads as well in the daytime when we began operation. With our education and by displays of very attractive salads, we educated the day workers to choose salads. After a short time, although it was mid-winter, the workers at night demanded salads too, and now we serve as many at night as during the day. We served the most attractive items on the night dinners, although the cost was slightly higher. Now we offer the same menu at night as in the day, but we garnish more lavishly at night.

Results of Education

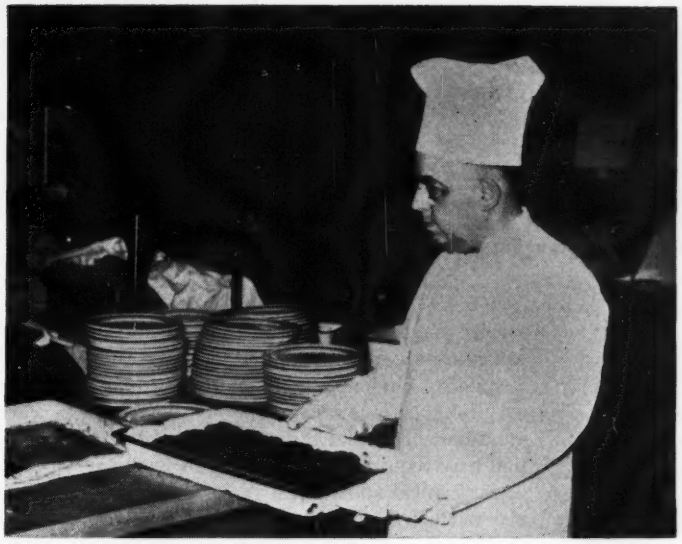
The Nutrition Services of Ottawa surveyed the choice of food by our workers. They found that 62 per cent. chose good dinners, 38 per cent. fair dinners and 12 per cent. poor dinners. The workers who carried their own lunches from home brought 9 per cent. good lunches, 50 per cent. fair lunches and 41 per cent. poor lunches.

Conclusion

We are attempting in this manner to provide and encourage the con-



The Cafeteria System Simplifies Service.



A competent chef is of great assistance.

sumption of a good healthy dinner in our war plant. We have adequate equipment, an excellent staff and the whole-hearted co-operation of the management. We feel that we are assisting the war effort by providing attractive, nutritious, low-cost meals for the war workers.

Health Insurance Measure Details Discussed with Federal Committee

THERE was increasing evidence during November and December that the health insurance situation has been receiving increased attention. Undoubtedly the Beveridge report, given such favourable publicity by the press, had much to do with this stimulation of interest and it is not improbable that repeated, though not fully justified, rumours of radical social demands being framed for the Winnipeg convention may also have been a factor. At any rate the Canadian Hospital Council had reason to believe that any further representations to be laid before the "drafting committee" should be done without delay.

Accordingly, the views of the C.H.C. Committee on Health Insurance respecting certain details presented to it for consideration in November, were discussed with the Federal Advisory Committee on December 17th. This supplemented the presentation of "Principles" some months ago (See *The Canadian Hospital* for October).

Among the points discussed were the following:

The insured person should have the right of selecting his own hospital from among those authorized as capable of providing the treatment required.

Hospitals utilized should be either non-profit, voluntary hospitals (lay and religious) or municipal hospitals, provided they conform to the required standards of service.

The governing body of each hospital should determine who shall be given the privilege of doing medical work therein (as at present).

Payment should be adequate and on either of two bases: (1) A basic rate for general care plus payment for extras, or (2) an all-inclusive rate without extras and to be determined for each individual hospital.

Normal accommodation provided should be ward accommodation, but patients might purchase semi-private or private space by paying the difference in charges.

In order to ensure adequate clinical teaching, most essential from the viewpoint of the future, any insured patient hospitalized in a teaching hospital, except on semi-private or private wards, should be available for clinical teaching.

It was recommended also that teaching hospitals should receive additional payment because of the additional facilities and personnel required and that the medical staff working on such closed wards should be given some remuneration.

The right of the hospital staff to divulge clinical data to the insurance commission should be clearly defined.

Transients from outside the province who are unable to pay should be paid for by the fund or the province.

An official formulary to simplify prescribing was recommended.

Convalescent care should be included.

Other points such as the nature of the federal and provincial authorities, representation of the hospitals on commissions or advisory councils and other details were discussed.

Suggested regulations to supplement the clauses of any measure drafted were presented to the Federal Committee some months ago.

No statement has yet been made as to whether or not this measure will go to the House at the forthcoming session.

Hospital Care Insurance Plan Delayed Awaiting Incorporation Approval

The actual launching of the Hospital Care Plan sponsored by the newly-formed Maritime Hospital Association has been delayed pending the incorporation of the Association. Inasmuch as the Association includes hospitals of three provinces, it was deemed advisable and necessary to apply for federal rather than provincial incorporation. The application is now before the federal authorities and it is anticipated that the delay will be but temporary.

The Committee in charge of the plan have done a great deal of work during the past few months and have accomplished much in placing the plan upon a practical basis.

Obiter Dicta

The Forthcoming Health Survey and Manpower Requirements

ELSEWHERE in this issue announcement is made of a proposed survey of the greatest importance to the health of this country. Nor has it come any too soon, for there is much evidence that our health facilities have been stretched too thinly in many areas and that something will have to be done if the health services in many communities are to be prevented from collapsing entirely. Provincial and other hospital associations and hospital workers generally are urged to give every support to this study. Although there is a shortage of all types of health workers, the situation has been increasingly serious with respect to doctors. Reports are constantly being received of large areas without adequate medical care. Three hospitals in Alberta closed recently because their doctors were all gone. One large area in western Canada covering 11,000 square miles and with over 4,000 people has only one doctor left—and he is over seventy years of age! One eastern area has one doctor to 13,000 people.

It was because of the need of rationing the supply of doctors to meet both civilian and military needs that the Medical Procurement and Assignment Board was set up in the first place. The Board found, however, that the doctor was but one cog in an inter-related system involving hospitals, nurses, dentists, technicians, public health organizations, industry and other factors. Moreover there was a vast lack of factual knowledge of the country's health needs and of the facilities available to meet such needs. Hence the new Order in Council.

But this matter will not rest with the assembly of some data. Despite a few weeks of cheering headlines in our newspapers, the Huns and the Japs are a long way from getting out the white flags. There will probably be many repetitions of the Dieppe raid and many costly battles before this war is over. Our health services have felt only a fraction of the disruption that is in store for us. National Selective Service is determined, and rightly so, that every last one of us will be doing what his country needs most and where it can best be done. Undoubtedly, as various situations develop, federal authorities will be given requisite power to put into operation plans to conserve manpower, to distribute it more equitably, and to promote greater efficiency. It is highly important that we in the hospital field face this situation squarely and be prepared to reduce our services to the very minimum if that be necessary. As communities we must be prepared to pool our manpower and our facilities and to re-allocate functions and activities if that be in the national interest.

Naturally we shall want safeguards. We shall want to know that we are not giving up skilled workers to military service and to industry unless they are being fully utilized in a more important task then they are fulfilling in civilian hospitals. Under certain conditions, financial recompense may be a serious consideration. Basically, however, we must remember that the exigencies of the manpower situation may require the whole field of health services to come under critical and radical review at any time. Therefore it is much better for us to do this ourselves and to do it so thoroughly and impartially that those in authority will be prepared to accept our recommendations for the various contingencies.

Doctor Caldwell Retires

DR. BERT CALDWELL, executive secretary of the American Hospital Association for the past fifteen years, has submitted his resignation to the Board of Trustees. Dr. Caldwell has also resigned as editor of *Hospitals*. For fifteen years Dr. Caldwell has been secretary of the Association, and now, at the age of sixty-eight, desires to take a well-earned rest at his beautiful farm in Shirland, Illinois. Dr. Caldwell has agreed to remain in office until his successor will have been named, which decision it is hoped can be made within the next few weeks.

Starting his medical career in Saint Louis in 1898, he joined the Isthmian Canal Commission and was put in charge of the various hospitals in the Republic of Panama during the building of the canal. When this was completed in 1915 he was made a member of the Rockefeller-Red Cross Commission to the Balkans. In the following year he was moved to the American Embassy in Berlin, when he became commissioner to inspect Allied prison camps in Germany. Later he returned to America to become superintendent of the Allegheny General Hospital in Pittsburgh. After serving in the American Army as colonel in the medical department he joined the U.S. Public Health Department. He was a member of the Yellow Fever Commission sponsored by the Rockefeller Foundation, during which time he was in charge of the Gulf Coast from Tampico to Yucatan. From 1922 to 1925 Dr. Caldwell was superintendent of the University of Iowa Hospitals at Iowa City, a post now held by Mr. Robert Neff. He then was put in charge of the Tampa, Florida, Municipal Hospital. He also saw service in the Spanish-American War.

During Dr. Caldwell's secretaryship the American Hospital Association has attained a position of influence and responsibility far beyond what was ever anticipated by its founders. The fine headquarters in

Chicago have been freed of debt and the Association has undertaken a great many new activities. A number of organizations and developments closely linked with the Association have been sponsored and assisted, such as the American College of Hospital Administrators, the hospital service plan movements and the Institute for Hospital Administrators.

Of particular importance has been his work as editor of the official magazine, *Hospitals*, which was expanded from the old quarterly bulletin during his tenure of office and in the direction of which he has shown so much enthusiasm and ability.

Few men have had the capacity for making friends as has had Bert Caldwell, and his forthright honesty and direct approach to all problems have earned for him the respect of his colleagues in his own and allied associations.

Human Races and Disease

THE recent story of Bessie Johnston, the 20-year old Indian girl in Teslin, Yukon, who heroically nursed members of her tribe struck down with measles until she herself was stricken and died, calls attention to the serious ravages of such apparently mild diseases when they are contracted by isolated peoples not hitherto exposed to them. In this case 128 of the 135 Indian inhabitants of Teslin were taken sick. Fortunately the death rate here was low, although, according to Dr. P. E. Moore of the Indian Affairs Department, from 25 to 30 per cent of the population of villages have been wiped out in similar outbreaks.

Obviously, immunity, or its lack, is the big factor. Some years ago when measles first struck the Malay Peninsula a full third of its teeming population over a large area succumbed to this new plague. With us, measles is comparatively mild for, as a race, we have developed a racial immunity. In 1348 when the Black Plague struck England, one-third of the entire population of the country is said to have died. The white race was slow to develope immunity to smallpox, one in five of the population in England before Jenner's time dying of this disease, and one in three of these who reached adult life being pock-marked. The American Indians had practically no resistance to smallpox and but little to tuberculosis and syphilis. Dr. J. J. Heagerty, in his most readable, *The Romance of Medicine in Canada*, says: "The arrival of the white man brought to the Indians new and to them unknown diseases that swept through them like a devastating flame." He refers to the almost complete disappearance of the Lucayan Indians of Mexico when smallpox brought by the Spaniards in 1520 wiped out three and a half million of them. Coming closer home he relates its overwhelming devastation among Canadian Indians. Many of these who survived committed suicide. "Everywhere was heard the wail of the sick and dying, and 'on or under the platforms at the sides of the house crouched squalid men and women, in all stages of distemper'."

With influenza, although we have some racial immunity, our protection depends largely upon an acquired and individual immunity. Most deaths occur among those under 25, older people, although they may contract the disease, usually showing much greater resistance to it. This, of course, is because so many of those in adult life have contracted the "flu" in an earlier epidemic. This explains also why the condition, although endemic nearly every year, reaches epidemic proportions in cycles of approximately 20-25 years. These cycles have been traced back for a couple of centuries.

Courage Under Fire

OUT of the horror of the Boston Cocoanut Grove fire have come stories of heroism and of devotion to duty which have provided a bright spot in an otherwise most tragic event. As hospital people we are particularly interested in the stories that have come from the hospitals of the way in which their medical, nursing and other personnel responded to the emergency call.

At the big City Hospital where so many of the injured were taken, the student nurses were holding a dance when the stream of victims began to pour into the admitting room. Immediately the dance was stopped, the girls rushed into their uniforms and went right on duty, separating the living from the dead, giving first aid to the scorched bodies still moving. Almost without cessation the nursing staff worked from Saturday evening until Sunday mid-night, cutting away charred clothing, applying dressings to denuded flesh and giving blood, oxygen and other restoratives. One hundred and thirty living patients were admitted to this hospital and seventy-nine to the Massachusetts General Hospital. One nurse at the M.G.H. lost three members of her immediate family, but she worked on steadily.

Nurse aides who assisted doctors and trained nurses in caring for these patients received virtually a baptism of fire which none of them ever anticipated. Two hundred were called out for duty to the City Hospital on Saturday night and one hundred for duty at the M.G.H. These aides had to search bodies for means of identification—a most trying ordeal. They mopped up the floors covered with blood and cinders and burnt clothing and flesh. They sterilized and washed equipment, changed soiled sheets, obtained needed supplies and acted as special nurses for the most seriously ill patients, doing many things that were never contemplated as duties to be assumed by volunteers. Many are the stories of the almost superhuman work done by these women, so many of whom had had no previous experience with such revolting sights. Many of them were so sickened that they had to leave the room at intervals—one admitted leaving the ward five times. But back they came to continue their ministrations.

Reports have not yet been received of what went on in the Newfoundland hospitals following the St. John's fire, but we have no doubt that equal courage and fortitude were shown there. We have no doubt but that it was on a par with that of the staffs of Boston hospitals and of the heroic lads in St. John's who willingly sacrificed their lives that their girl companions might be saved.

How would you like to have this view from your front door? This is the view from the R. W. Large Memorial Hospital at Bella Bella, B.C. Along the coast everything must be moved by water and long trains of barges and floats are a common sight, as in this illustration.

National Nutrition Programme Announced by Government

THE knowledge that malnutrition is rife in Canada, one of the world's greatest food-producing countries, has come as a shock to the average Canadian. The effects of malnutrition, especially of the so-called "borderline cases" are usually not spectacular. The results are essentially negative—a lack of health, rather than the presence of a specific disease. But this general debilitation can be just as deadly in the long run.

What has really focused public attention on the problem is the fact that so many young men who have been rejected for military service—men who should have been at the peak of their health and strength—have been rejected for disabilities which could be traced in large part to a deficient diet over a period of years.

Much of this condition can be blamed on the economic effects of the depression. But economic factors are not the only consideration. To quote from the official pamphlet, *The Canadian Nutrition Programme:* "High incomes or high expenditures on food are not, in themselves, guarantees against malnutrition". Ignorance of, or indifference to, the principles of a sound diet play just as large a part. Indeed, during the period of comparative prosperity which the country is now enjoying, they are the most important causes of the malnutrition which still persists.

Canadians must be weaned away from the idea that a big meal must necessarily be a good meal. The reverse is often true—e.g., the discomfort that most people feel after Christmas dinner. As a rule we eat *too much of the wrong kind of food.* "The *basic principle* (of the Government's programme) is that Canadian people need to get more calories from protective foods. The over-use of starchy, fatty and sweet foods completes a person's energy requirements and satiates the appetite before sufficient vitamins and minerals have been obtained. Therefore our aim must be to increase the percentage of the day's calories which are supplied by protective foods."

The "protective foods" include milk, cheese, fruits, especially citrus fruits, vegetables (the leafy green or yellow are recommended particularly), meat or fish, eggs, cereals and whole wheat bread. The inclusion of these foods in the daily diet has been advocated by doctors and dietitians for years. But apparently there is still a vast amount of educational work needed before they are accepted by the individual homemaker.

Elsewhere in this issue we publish an interesting account of dietary problems in a munitions plant. The wise refusal of those in charge of the cafeteria to pander to the "sandwich and soft drink" habit has had gratifying results. The increase in the consumption of milk, of whole wheat bread and of salads shows what can be done by an unobtrusive programme of education. Hospitals, too, are in a peculiarly fortunate position with respect to dietary education. The instinctive, vague belief of the average patient that everything done for him in the hospital, from anaesthesia to bed-baths, is somehow intended to "make him better" can be used as the basis of his nutritional education. An explanation of why orange juice is included on his breakfast tray and of what is meant by a "balanced diet" will probably find him in a more receptive mood than if he read about the same things while he was perfectly well.

Saskatchewan Hospitals Seek Increase in Municipal Rate

MEMBERS of the Executive Committee of the Saskatchewan Hospital Association met the Premier and a number of cabinet ministers on November 26th, when they requested an amendment of the Rural Municipalities Act to permit an increase in the daily rate for indigents from $2.50 to $3.00.

The delegation included President C. C. Gibson, Mr. Leonard Goudy, Mr. W. C. Ryan, Mr. S. H. Curran, Mr. S. N. Wynn and Mr. G. E. Paterson. The delegation was received by the Premier, Minister of Health Dr. Uhrich, Minister of Municipal Affairs R. J. M. Parker, Minister of Education Staines, Minister of Natural Resources Kerr and the Deputy Minister of Health, Dr. Davidson.

The deputation pointed out that hospital costs have gone up some 35 per cent over the 1939 level and are still rising. While some increases have been made in private patient ward rates and some other charges, these have been totally inadequate to meet the increased operating costs. The present rate of $2.50 per day has been in effect ever since Saskatchewan was made a province and is in need of revision. It was shown that most of the larger and more important hospitals in the province were showing a deficit. Forty of the eighty hospitals of the province show a cost per patient day of over $3.00.

The importance of the hospitals in maintaining the health and morale of the people was stressed. This is a direct and most important duty of government, even though some of the responsibility is delegated to the municipalities and to private support.

The percentage of bed occupancy increased from 65 per cent in 1940 to 69 per cent in 1941. Many of the hospitals are seriously overcrowded, and face the necessity of adding to their capacity.

It was pointed out also that ten of the hospitals showing deficits operate schools for nurses. It is a fact that a hospital staffed by graduate nurses can operate at less cost than one which has a training school. By graduating nurses at no direct cost to the province but at a cost to themselves, the hospitals have been performing a service which should be recognized. It is pointed out that in the United States and elsewhere hospitals operating schools for nurses are frequently the recipients of annual grants for this particular service.

Impetus to the idea of classifying hospitals acording to operating costs has been given by the fact that the Association of Rural Municipalities does not object to the increased rate for those hospitals showing deficits, but does not desire it to apply to some of the smaller hospitals operating satisfactorily on the present $2.50 rate. This idea of classification was supported by the deputation in its presentation.

The satisfactory way in which fall exhibitions have been classified as A, B, or C fairs for the receipt of government grants was cited.

The deputation was given a sympathetic hearing and full consideration of their request was promised.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

After an interval of four years due to war conditions, the H.S.A. has held once again a large central meeting to present a report to those immediately concerned in carrying it on. The initials are well known throughout greater London though the title is frequently stated inaccurately. The Hospital Saving Association was formed twenty years ago to save the hospitals, owing to the serious effect of the war upon their finances.

In the negotiations and discussions for the formation, guided by the late Lord Hambleden, the voluntary hospitals of London, incredible as it may seem, learned for the first time to work together for a common object. Care was taken to mark the voluntary character of the undertaking by describing those who joined as "contributors". The use of the word "member" was avoided in order that they might not think of themselves as members of a society entitled to a benefit. Nevertheless in course of time the initials H.S.A. are frequently expanded into Hospital Savings Association under the impression that the contributors save to meet the cost of a serious illness. Thus from being a benevolent effort on the part of the wage earners of the community it tends to be regarded more as an insurance scheme. In the first year there were 193 groups containing 15,356 contributors who raised a sum of £2,176. In the year before the war there were nearly 14,000 groups with more than two million contributors who raised £1,154,810. At the beginning of the war there was some loss of members, mainly owing to evacuation, but the strength of the organization has been demonstrated by its recuperative powers. There has been loss of life among the workers, the homes of others have been destroyed and yet the work has been maintained with unflinching courage. In the course of twenty years the Association has provided more than £10,000,000 and —as the Chairman, Sir Alan Anderson, pointed out to the group secretaries—the present income, raised by payments of threepence a week, represents a capital value between £20,000,000 and £30,000,000.

The role of the H.S.A. in the present British health system.

Contributory Schemes

The H.S.A. is the largest of the contributory schemes all over the country, ranging from those in large cities like Liverpool, Birmingham and Sheffield to groups of a few hundred attached to small cottage hospitals. They represent much more than merely a means of raising money for the support of voluntary hospitals. A contributory scheme embodies the corporate expression of the community in an act of service. That is why the H.S.A. operating through the Greater London area is such a remarkable organization, as its sphere is an amorphous agglomeration without any co-ordinated unity.

The Association, by combining nearly two million contributors in one organization, has succeeded in bringing together people in an area where there is nothing comparable. It was meet and right that the Minister of Health, Mr. Ernest Brown, should welcome the opportunity at a great gathering of supporters to give cordial expression of his appreciation of this work.

It must be admitted, however, that there is a considerable field undeveloped and that there are still many potential members who might be enrolled. Also, in response to the express wish of the hospitals, the Association has not approached employers to contribute their quota of one penny for every threepence given by their staffs. The amount from this source has increased but does not form such a substantial portion of the income as in some provincial schemes. In another respect the London scheme does not *appear* to be so successful as the provincial, as the Association pays to the hospital a smaller proportion of the cost of the patient. This is due to the fact that London hospitals are costlier than in the provinces and within easier accessibility so that the Londoner is more "hospitalized" than his country cousin.

The Outlook

Proposals to extend health insurance to include hospital benefit and the dependents of the insured person look as if their adoption may lead to the extinction of the contributory associations. Alarm has been expressed on the subject and there are signs of opposition to the adoption of any such proposals by the Government. On the other hand it seems to be a natural development of the idea which has gained ground that the contributory scheme is a form of insurance. Moreover, before the Beveridge scheme seized the imagination of the public, it had to be admitted that the English health insurance system was quite exceptional in not including a hospital benefit and the members of the family. Even if its extension rendered the contributory schemes unnecessary for that particular purpose it would not follow necessarily that they should become extinct. There would still be ample scope for their original purpose of giving practical expression to the goodwill and devotion of their contributors to the work of the voluntary hospitals.

Abbott announces a large volume intravenous solution with important B Complex factors

● Recently it has been recognized that the task of metabolizing post-operative intravenous feedings of dextrose in a patient already having a reduced store of the B Complex group of vitamins may exhaust that store and result in acute deficiency. Consequently, a number of investigators state that it is a wise prophylactic measure to administer thiamine hydrochloride, riboflavin and nicotinic acid to all patients who receive dextrose fluids parenterally. ● To satisfy the need for a large volume parenteral dextrose-saline solution containing these B Complex factors, Abbott Laboratories has developed Beclysyl. ● This solution, while suitable for use in all cases requiring the parenteral administration of dextrose in saline, is particularly indicated in post-operative states associated with nausea and vomiting, hyperemesis gravidarum, and in cases where intestinal obstruction or other intra-abdominal disease would cause persistent vomiting. ● Each liter of Beclysyl contains in chemically pure water free from pyrogenic substances: 50 Gm. Dextrose ; 8.5 Gm. Sodium Chloride; 3 mg. Thiamine Hydrochloride; 3 mg. Riboflavin; and 25 mg. Nicotinamide. ● Beclysyl is supplied in a special Abbott Liter Container coated with a black lacquer to protect the riboflavin content. Two readily removable strips of tape, one on each side of the bottle, allow the operator to determine the solution level during administration.

Beclysyl

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Here and There

By The EDITOR

A Vintage that is Gone

THE latest issue of the *Historical Bulletin*, published by a group of literary-minded members of the Calgary Associate Clinic, has a most interesting article on Doctor Bertram Spencer, one of the most colourful professors at the medical school in Toronto in the 'nineties and until his death in 1902.

This biographical sketch has been written by Dr. F. Arnold Clarkson of Toronto, who has as fine a literary pen as exists in the medical profession today. To excerpt from Dr. Clarkson's essay:

"I am sure the class of 1901 will never forget our startling introduction to the man who was to have such an influence over us for the rest of our lives. At that time the medical faculty was comparatively small, perhaps about two hundred all told, so that we had an annual dinner of all the years. In 1898 the guest speaker was no less a person than the Governor-General, Lord Aberdeen. This, however, was only an item in the lives of the second year, (which was us) and our table was so noisy while Aberdeen was speaking that we became very unpopular. Finally some of the professors came down from the dais and implored us to keep quiet, but without success, till a short vigorous man, with butler's sideburns, thin lips and rather laughing eyes, elbowed his way through the boisterous crowd and shouted, "Men of the second year! I'll have you in my class next year, and if you don't stop this infernal racket I'll pluck every blank blank one of you" —only he filled in the 'blanks.' In frightened whispers we asked, "Who's that?" and some of the seniors told us, "Bertram Spencer." His method of restoring order worked, and there was no more trouble.

"He had, as a coroner, ample opportunity to see at first hand, cases which would be useful to us in later years. There was the Chinaman who playfully slit open his belly with a butcher knife; and the doting mother whose daughter Spencer said was pregnant, but who declared such a thing was impossible, for she was "pure as the angels." "Well," said Bertram, "maybe so. I don't know much about angels." It may have been the same woman who attempted to blackmail him. After a bimanual examination, Spencer received a letter from a firm of lawyers threatening a writ for assault. His answer was short and to the point, beginning, "Dear Sirs: Your damned impudent letter is now before me." Unfortunately the censor would delete the last sentence if I were to repeat it, but it is enough to say that he expressed his contempt for them in a thoroughly French way. It reminds one of the famous reply of the Duke of Wellington: "Dear Nell: Sue and be damned."

"His blood was not dishwater. One day he entered the male surgical ward in the old General, to find a visitor with his hat on. Bertram asked him politely to take it off, whereupon one could see that the man had a flattened nose, that marked him down either as a prizefighter or a syphilitic. At any rate his face and bearing were bellicose to the extreme. He paid no attention to Spencer's request, which was repeated in the staccato of the quarter deck. No movement. With the lightning-quick blow of a trained boxer, (which he was) Bertram knocked the derby hat clear across the ward. The victim instantly assumed the fighter's stance, but was so quickly seized by the students and hustled out of the building that he hardly knew what happened.

"In spite of his abrupt manner, no one could be kinder to a patient. Students were constantly reproved for their lack of gentleness at the bedside, and he taught them some of the art, at any rate, of handling a tender joint with the least pain. Better for them to get reproof from their teacher than from the patient. Medical students seem to have had cold, rough hands since the beginning of the Christian era. Martial (died A.D. 100) writes: "Languid I lay and thou camest, O Symachus, quickly to see me. Quickly thou camest and with thee an hundred medical students. The hundred pawed me all over with hands congealed by the north wind. Ague before I had none, but now, by Apollo, I have it."

Although it was not in 'the urn of unrelenting fate' that he should be granted the perspective and serenity of mellow years, he left his mark upon those students who were fortunate enough to hear his voice. He has entered into their Valhalla, and his memory will retain its fragrance as long as the best spice that was ever expended on one of the Pharaohs."

* * *

Canadian Hospital Room Moved to Holland!

Or, at least, that is what it amounts to. The Ottawa Civic Hospital, by virtue of its location, has many interesting patients and unusual experiences. Now one of its suites is to be officially declared part of the the Netherlands so that the next child of the Princess Juliana can be born in Holland. The Canadian government has arranged to make these extra-territorial arrangements so that there may be no citizenship complications for the possible successor to the Dutch throne.

It has even been arranged that a traffic delay would not cause international complications.

* * *

Drug Store Medication

A certain evening newspaper which is published in the East and which boasts a daily circulation of over a quarter of a million, has a choice one in its questions and answers column.

In response to the letter of a parent who signs herself "Frantic" and who apparently has become that way because of a child suffering from enuresis (bed-wetting to the uninitiated), this great newspaper solemnly furnishes sage advice which begins as follows: "Consult your druggist who could probably furnish a preparation which would be of assistance in breaking the child of the bad habit."

Make Your Food Slicer Last Longer

By W. C. ALGUIRE, Toronto

PROLONGING the life of kitchen equipment is one of the new and foremost problems with which management must deal.

Too much importance, therefore, cannot be placed on the value of frequent cleaning and regular lubrication. Aside from the scarcity of replacement machines, such a planned and executed programme is decidedly in the interests of economy. In other words, proper care or preventive maintenance not only reduces repair bills and helps to prevent serious breakdowns, but increases the efficiency of the slicer and eliminates waste due to faulty operation.

Our first responsibility is to recognize the cause of various complaints —to learn how to deal with each one most economically.

Thick and Thin Slices

Usually the cause is a dull knife. *Always bear in mind that the cutting knife must be kept sharp. Good cutting cannot be done with a dull hand knife, and neither can a slicer do a perfect job unless the knife is sharp.*

If you find the knife to have a keen edge, check the feeding system. In the hand or flywheel operated type of machine, the feed nut may have worn sufficiently to allow play between the feed nut and the thread of the feed screw. Another source might be the pawl blade which, if out of adjustment or badly worn, will not engage the pawl wheel properly, thus resulting in uneven slices. Either of these parts may be procured from the manufacturer at a small cost.

Tearing and Crumbling of Slices

When meats or bread begin to "tear and crumble," nine times out of ten the trouble is a dull knife. The first procedure, therefore, is to apply the automatic knife sharpener until a keen edge is obtained. *Important:* As accumulated grease and fat particles greatly impair the effectiveness of the sharpening emeries, be sure that they are thoroughly cleaned. It is to be noted here that the sharpener stones should be replaced periodically. Badly worn emery stones cannot possibly sharpen the knife, and replacement should not be delayed, as continued use is liable to result in harm to the cutting knife.

If the sharpener stones are clean and in good condition and the automatic sharpener still does not restore a thin edge, it is likely that, due to ordinary wear, the knife has developed a heavy edge or thick bevel and requires regrinding. This is a factory job. Do not entrust it to an amateur knife grinder, but only to the skill and experience of a manufacturer.

Motor and Electrical Connections

Your slicer motor is built for intermittent use. Do not allow it to operate unnecessarily for long periods.

A "smoking" motor usually indicates over-oiling. Do not oil more than once every six months. Use light oil only.

"Stopping" may be the result of either motor or switch trouble. In either case it is best to get in touch with the manufacturer at once.

Electrical supply cords are now *on* the rationed list. Keep the cord free from accumulated grease or fat particles, which attack and deteriorate the rubber covering.

Use the Manufacturers' Service Facilities

Most slicing machines are built so that compensation can be made for wear from time to time. For instance, as the knife wears smaller, so the automatic knife sharpener can be adjusted accordingly. Similar adjustments can be made to the thickness gauge plate, driving mechanism, etc. Protect your principal investment, and secure peak efficiently by having the necessary adjustments made periodically.

Your present equipment may be the last for the duration. Don't let anybody monkey with it. The manufacturer has the right tools, the right skill, and the right service facilities to do an A-1 job.

Mr. Alguire is Manager of the Service Department of Berkel Products Co., Ltd.

Year's Leave for Dr. Hewitt

Dr. S. R. D. Hewitt, superintendent of the Saint John General Hospital, has been granted one year's leave of absence by the hospital commissioners. This was requested on account of ill health. In granting this leave the Board paid strong tribute to his faithful service to the hospital for the last 11 years and recorded the Board's appreciation of his outstanding service, not only to his own hospital, but to hospitals throughout Canada.

Mr. R. H. Gale, business manager of the hospital, has been named acting - superintendent during Dr. Hewitt's leave of absence. Mr. Gale was superintendent of the old hospital before the present large structure was built. His long years of experience and his proven ability qualify him for this responsibility.

His many friends in the hospital field wish Dr. Hewitt a rapid and complete recovery.

Urology Award

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the programme of the forthcoming meeting of the American Urological Association, May 31-June 3, 1943, in the Hotel Jefferson, St. Louis.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 1st,

New Rulings by Control Boards

Essential Male Occupations in Hospitals Announced

AS we go to press, announcement is received from National Selective Service of those male occupations in hospitals which are considered as essential by N.S.S. Mr. John J. Deutsch writes as follows:

"This matter was discussed at a recent meeting of the Interdepartmental Committee on Labour Priorities, composed of representatives from the Department of Munitions and Supply, Wartime Prices and Trade Board, and National Selective Service. At this meeting a decision was reached to specify the following occupations in hospitals for a high labour priority rating for men:

Orderlies
Engineers and firemen
Carpenters and repairmen
Painters
Electricians
Plumbers
Porters
Incinerator men
Butchers
Laundry washmen and extractor men
Night watchmen

This step should help you to obtain male staff for essential hospital labour.

Our local employment offices have been advised acordingly, and your hospitals must continue to place their requirements for labour with the Employment Office in the city in which they are located.

Yours very truly,

(Signed) JOHN J. DEUTSCH,
For the Director."

Women employees have already been given a high category standing and this ruling now places certain groups of the male employees on a high labour priority rating. Most of the occupations for which the Canadian Hospital Council requested consideration have been included. We note, however, that this list does not include chefs or cooks, laundry superintendents, store keepers and receivers, groundsmen, morgue attendants, wall washers and window cleaners, chief accountants and country collectors.

Despite the lack of rating for the above-mentioned groups, the ruling is a favourable one and should be of much assistance to hospitals.

Order P.O. 1 Revoked

On December 15th, 1942, all sections of Priority Officer's Order No. P.O. 1 were revoked. This was the Order setting up the Allocation Classification System in Canada. Hereafter it will not be necessary for Canadian industry to indicate the appropriate Allocation Classification symbol (D.P. in the case of hospitals) on purchase orders.

This action was taken following the decision of the War Production Board in Washington to revoke the priorities regulation which covered the Allocation Classification System in the United States. Washington has now developed a Controlled Materials Plan, (C.M.P.). This will require Canada to submit her U.S. requirements in a similar fashion. Details as to how this will be done are now being formulated at Ottawa and will be announced shortly.

No Change in Supplier Without Authorization

The attention of superintendents and purchasing officers is drawn to the statement of the Wartime Prices and Trade Board that *no operator of an institution may change his supplier of rationed commodities except with authority of the Administrator of Consumer Rationing,* and any application for a change must be accompanied by a statement of good and sufficient reasons. This order applies to suppliers of sugar, tea, coffee and butter.

Butter Rationing

The regulations respecting the rationing of butter are similar to those governing the rationing of other commodities. Hospitals must register with the Board on or before February 1st as a user of butter, and must name their supplier.

"Every operator of an institution shall obtain from each person entering such institution with the intention of *residing therein for one week or longer,* his ration book or card, . . . and shall detach one butter coupon at the expiration of each period of one week during which such person continues to reside in such institution."

All such detached butter coupons are to be forwarded at least once each month to the Administrator accompanied by the form provided by the Board, and duly completed.

An accurate record must be kept of the purchase and use of all butter consumed in the hospital, and this record must be ready for inspection at any time.

Tax on Antiseptics

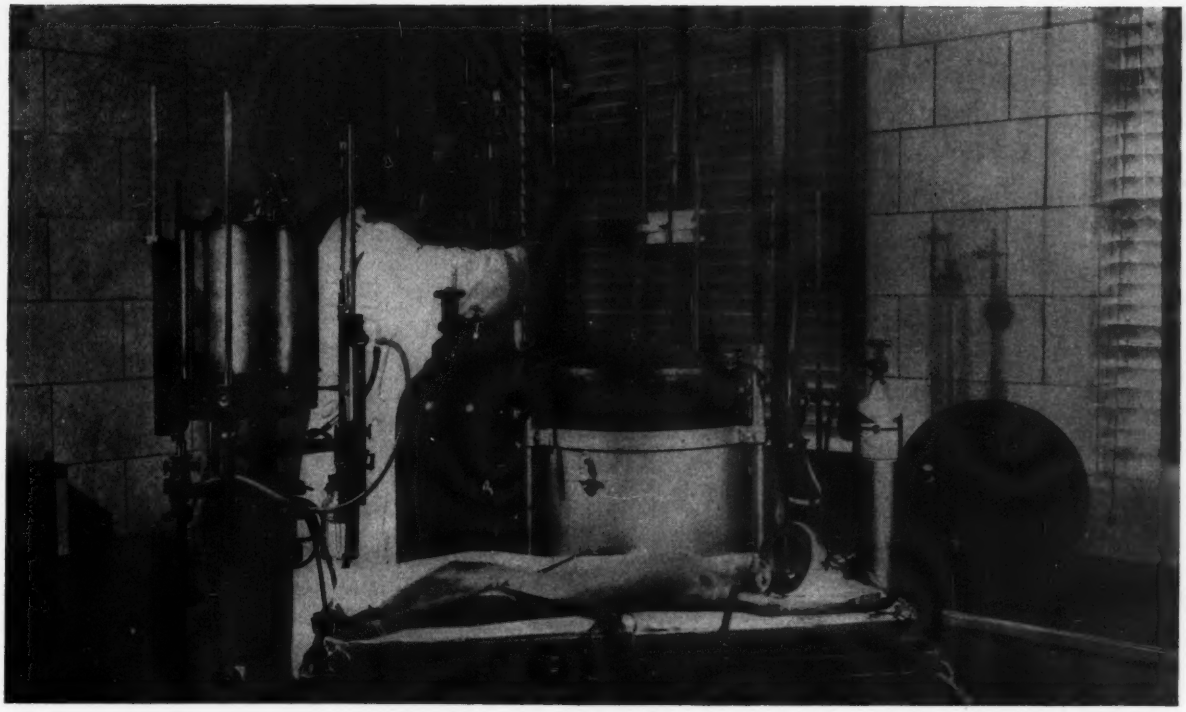
An enquiry has been received from a hospital secretary asking if there is an excise tax of 25 per cent on antiseptics.

There is, we regret to say. We are informed by the Excise Division of the Department of National Revenue:

"Effective on and from April 30, 1941, an excise tax of 25 per cent is applicable on sales and deliveries by manufacturers and on importations of antiseptic solutions which prior to that date were subject to excise tax of 10 per cent, the tax rate having been increased from 10 per cent to 25 per cent as of that date.

"Sales of antiseptic solutions to bona fide public hospitals are subject to the excise tax of 25 per cent as the provision made by the Special War Revenue Act for exemption from sales tax on sales of articles and materials to bona fide public hospitals, certified as such by the Department of Pensions and National Health for the sole use thereof and not for the purpose of resale does not extend to the excise taxes imposed by the Act."

(Section 80 (1) of the Special War Revenue Act states that any goods mentioned in Schedule I and II of the Act imported into Canada, or taken out of warehouse, or manufactured or produced in Canada and delivered to a purchaser shall be subject to an excise tax at the rate specified. Schedule I, Sec. 2, lists antiseptics, along with various cosmetics and toilet articles, as being subject to an excise tax of 25 per cent.)



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Hospitals Have Definite Place in Public Health Programme

Chas. F. Wilinsky, M.D., Boston

THE prevention of disease, the promotion of health, the cure of illness, are the concern of hospitals as well as health departments, and non-official health agencies. All must play a part in the furthering of an adequate public health programme. The line of demarcation between prevention and treatment is invisible. All must accept the responsibility, all may derive satisfaction from the results.

Hospitals are indeed definite and important factors in the furtherance of the protection of the public health, by:

1. Caring for the sick.
2. Training of personnel.
3. Promotion of research.
4. Fostering health knowledge.
5. Conducting of essential clinics, and other services of inestimable public health value, which may include:
   - (a) Prenatal, natal and postnatal care.
   - (b) Care of infant and preschool child.
   - (c) The hospitalization of the communicable diseases.
   - (d) Diagnosis and treatment of tuberculosis.
   - (e) Diagnosis and treatment of diabetes.
   - (f) Diagnosis and treatment of nephritis.
   - (g) Diagnosis and treatment of cardiovascular disease.
   - (h) Diagnosis and treatment of cancer.
   - (i) Diagnosis and treatment of venereal diseases.
   - (j) Care of the cripple.
   - (k) Diagnosis and treatment of eye, ear, nose and throat conditions.

It is the practice in certain communities for health departments to establish treatment clinics, too frequently duplicating in their nature those maintained by local hospitals. This is not only illogical, but frequently a source of great irritation to the local medical profession. Every effort should be made to utilize existing hospital resources.

Hospitals are, indeed, an essential component part of the community health programme. They make available facilities for the care of the acutely ill, the convalescent and the chronic. They provide for those suffering from the communicable diseases. In many places ninety per cent of the babies are born in hospitals with advantage to mother and new born. The mentally unfit and those suffering from tuberculosis occupy more than a half million of our hospital beds. Our out-patient clinics fulfil most essential functions in the care of the ambulatory patient. Every hospital may be fittingly regarded as the "health centre" of the community, where prevention and treatment may ideally go hand in hand.

There is, however, still much to do. Surely, the revealing prevalence of many physical defects resulting in the rejection of approximately fifty per cent of our draftees suggests the urgent need of greater utilization of facilities for the correction of these physical deficiencies, in order that the standard of individual and community health might be raised. This is sound public health practice and procedure which calls upon the resources of our medical profession, who utilize the facilities of our hospitals, clinics, and allied institutions.

The most prevalent defects found among those appearing before draft board physicians were of teeth, vision, hearing, cardio-vascular, venereal, mental and nervous conditions, hernia, musculo-skeletal, etc. Representatives of the Medical Division of Selective Service urge the rehabilitation of approximately one million rejectees. In this performance the medical profession, our public health agencies, our hospitals and our clinics, working together for the common good, may contribute ma-

(Concluded on page 42)

From Address by Charles F. Wilinsky, M.D., Deputy Health Commissioner, Boston, and Executive Director, Beth Israel Hospital, at 1942 New England Institute for Hospital Administrators, of which he was the Director.

Noise Disturbance in Hospitals

(A Series)

No. 12—Metal Lockers

Metal lockers are exceedingly convenient and have certain advantages over wooden lockers. However, they are noisy at times and the slamming of the door may prove annoying to patients, particularly at night. Where metal lockers are used a great deal, particularly when patients are resting, it is well to have them outside of the room and around the corner if at all possible to minimize the disturbance. In the illustration the lockers are too close to the open doorway to expect much reduction of sound.


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Hospital Care Plans Given High Praise on Radio Hookup

A.H.A. President Hamilton Speaks on C.B.C. Coast-to-Coast Broadcast

When James A. Hamilton, President of the American Hospital Association, was in Toronto attending the convention of the Ontario Hospital Association, arrangements were made for him to speak on a coast-to-coast C.B.C. hookup on the subject of hospital care plans. Mr. Hamilton spoke of the value of these plans, making particular reference to the "Blue Cross Plans" which are the 70-odd plans which comply with the requirements laid down by the A.H.A. Mr. Hamilton's full address has been printed by the Ontario Plan for Hospital Care, the following paragraphs being excerpted from that address.

"SHALL we for the moment shift our attention from the war front and discuss another army, the largest in the world—an army so large that it outnumbers the entire population of the Dominion of Canada. I refer to the army of Blue Cross Subscribers—over eleven million of them in North America, banded together in the common defence of their health. Every day, another group of five to ten thousand persons joins this army. And it is well that they join in such numbers, for every year over a million of them go to the hospital for service and rehabilitation.

"The hospitals of Canada, many of which belong to the American Hospital Association of which I am President, have done a fine job of educating the citizens of their area to the importance of prompt hospital care. Figures show that the average hospital stay of a patient totals about ten days. During that ten days the patient is out of work, where he may be badly needed, and if the patient is a woman, she is absent from the home for ten days. These same figures showed that the average hospital stay of the Blue Cross Subscriber was only eight days. That's a paradox, isnt' it? The man who has no worry as to his hospital bill and who could very well stay in the hospital an extra day or two—just for good food and back rubs if for no other reason, goes home two days earlier than his worried room mate. What is the reason? The only possible answer is that the man with hospital care assured him goes to the hospital at the first suggestion of his dotcor. He doesn't delay for lack of money. He doesn't let a minor complaint develop into a major one. He goes in the hospital sooner and gets out earlier. In the United States, this saving in hospital days has been computed to total sixteen million man-hours. And you and I know how valuable that time is.

"Earlier in my talk, I gave the impression that these plans began operation only ten years ago. And that is true about the approved Blue Cross Plans. But fifty years ago, one hundred years ago, various methods were being tested in Europe, in Canada and in the United States. None of these plans, however, became as popular as the Blue Cross Plans. Canada has long been a leader in the movement for better hospital care for its citizens. Many hospital plans were organized across Canada, notably in British Columbia, which province to-day has the largest number of purely local community endeavours along this line. One of the oldest plans in Canada, operated along the lines of the approved hospital service plan as we know it to-day, is located in the city of Edmonton, Alberta. For eight years the city of Kingston, Ontario, has had a hospital service plan, now part of Plan for Hospital Care sponsored by the Ontario Hospital Association. The province-wide development of Blue Cross Plans commenced with the inauguration of the Manitoba Hospital Service Association in 1937. This plan, serving the province of Manitoba now has 80,000 participants. The second provincial plan resulted from an exhaustive study by the hospitals of Ontario, through their own association. It sponsored Plan for Hospital Care for the province of Ontario and enrolled its first subscribers on March 17th, 1941. The plan now serves over 120,000 participants. In May, 1942, a third provincial plan was established in Quebec. It is named the Quebec Hospital Service Association and has headquarters in Montreal. The Plan was approved as a Blue Cross Plan during the War Conference of Canadian and American Hospitals in St. Louis this month.

BERT W. CALDWELL, M.D.

Secretary, American Hospital Association and Editor of Hospitals whose resignation has been submitted.
(See editorial page 24).

"The hospitals of the three Maritime Provinces, Nova Scotia, New Brunswick and Prince Edward Island, are combining in a plan which is anticipated to be in operation soon.

"This is truly a remarkable development for Canada and one which is bound to have a beneficial effect on the health of all Canadians.

"Interest in the health of the citizens has prompted the Government to make studies as to the best method of assuring good hospital care for the people. Conferences of officials to discuss a Dominion Health Insurance plan have eventuated in an Order-in-Council (February 5th, 1942) authorizing the appointment of an Advisory Committee on Health Insurance to aid in studies and in the formulation of a plan. It is my hope that in the development of a national health programme for Canada that a place will be found to utilize the knowledge and services of the Blue Cross Plans.

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OBITUARIES

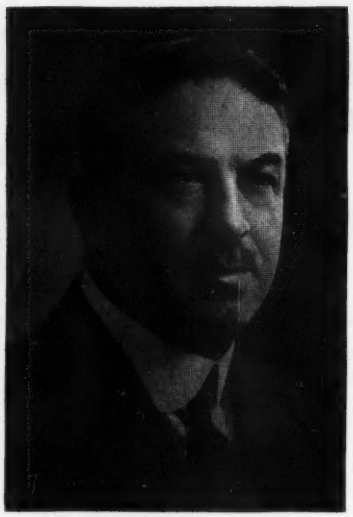
Jabez Henry Elliott, M.D.

A pioneer hospital superintendent and one of the greatest authorities on this continent on the history of medicine, Doctor Jabez Henry Elliott of Toronto, died on December 18th. Dr. Elliott had long been one of Canada's leading authorities on tuberculosis and was the first superintendent of the first tuberculosis sanatorium in the country, the Muskoka Cottage Sanatorium, which post he held from 1898 to 1907.

Staff physician in several Toronto hospitals, he was a teacher in clinical medicine at the local university from 1907 until his death, holding the chair of the history of medicine since 1931. Dr. Elliott was always interested in old books and was the leading spirit in the development of the large and famous medical library at the Toronto Academy of Medicine. He was active in many organizations and at the time of his death was president of the American Association of the History of Medicine. He has been president of the Academy of Medicine, president of the American Climatological and Clinical Association, president of the Canadian Tuberculosis Association, vice-president of the American College of Physicians, president of the Canadian Military Institute, and held high offices in the National Tuberculosis Association, the American Sanatorium Association, the Ontario Laennec Society, the Aesculapian Club and various fraternities and lodges.

Dr. Elliott spent some time in tropical Africa shortly after graduation and continued to maintain his interest in tropical diseases. He held the rank of Lieut.-Col. in the C.A.M.C. in the first Great War, and was the author of many articles on tuberculosis and the history of medicine. He also wrote a small volume some years ago on the flora of the Muskoka district.

Although a consultant in chest diseases when in the city, he delighted to retire to his summer residence in Muskoka for the entire season of three or four months, during which time he did general practice among the cottagers. His motor boat was a familiar and most welcome visitor to all parts of the lakes.



Jabez H. Elliott, M.D.

We can ill afford to lose men of such boundless enthusiasm, diversity of interests, keenness of mind and humanitarian instincts as Dr. Jabez Elliott. He represented a generation of broad education and deep cultural interests, and his passing has left a gap which few of his younger confreres can ever hope to fill.

* * *

Thomas Cox

The hospital field in Alberta suffered a great loss in the death on November 21st of Thomas Cox, secretary-treasurer of the University of Alberta Hospital at Edmonton.

Born in Waterford, Ireland, September 2nd, 1892, he came to Canada in 1911. Joining the 4th Field Ambulance in Calgary in 1914, he served overseas until invalided back in 1918.

From a patient in the Military Hospital he became a member of its staff and continued so after the absorbtion of the hospital by the University of Alberta in 1922. When the University Hospital was set up as a separate unit in 1929, Mr. Cox became its first treasurer and remained so until his death. For a year prior to last June he was acting superintendent as well. In 1919 he married Miss Jean McCallum, a nursing sister on the staff of the Military Hospital.

Mr. Cox was active in hospital organizations, having held various posts in the Alberta Hospital Association, and being its president in 1939. He was also an enthusiastic supporter of the Canadian Hospital Council and had taken an active part in its committee work. At the time of his death he was chairman of the Committee on Hospital Finance. He had also been active in various returned soldiers' organizations, the Great War Veterans, the Canadian Legion and the Canadian Corps Association.

His many friends in the hospital field will miss his genial presence very much. An efficient executive, a keen debater and a cheery companion, he was deeply loved and respected by all who knew him.

* * *

Honourable Murray MacLaren, M.D.

The Honourable Dr. Murray MacLaren, formerly Minister of Pensions and National Health for Canada and former Lieut.-Governor of New Brunswick, died in Saint John on Christmas Eve. In his 82nd year at the time of his death, Dr. MacLaren had had a long and distinguished career.

Starting as a country practitioner, he so gained the respect of his colleagues that he was elected president of the Canadian Medical Association in 1913. He saw considerable service overseas in the first Great War, being first Commander of No. 1 Canadian Hospital at Etaples, and later being director of the Canadian medical services. Later he was honoured by being made a Commander of the Order of St. Michael and St. George, Knight of Grace of the Order of St. John of Jerusalem and Commander of the Order of Avis, Portugal.

Elected to the House of Commons in 1921, Dr. MacLaren entered the cabinet in 1930 as Minister of Pensions and National Health.

Dr. MacLaren was always deeply interested in the welfare of hospitals and did much during his later years in the House to assist hospitals in obtaining favourable consideration in various legislative enactments, particularly with respect to tariff concessions.

Three Proposals Social Advancement British People

(Continued from page 19)

schemes of health, unemployment and pensions insurance in 1938-39 cost £342,000,000, with possibly another £1,000,000 added since the outbreak of war for extended services.

Comments

The announcement of these programmes of greatly augmented social security for the rehabilitation period would indicate that major changes may be anticipated within the next few years. There is no doubt but that the Beveridge Report is going to receive tremendous criticism in the House of Commons and elsewhere. Many of these changes have been urged by advocates of social reform for many years, but it has taken the stimulus of war to crystallize these ideas into official recommendations. To quote Viscount Dawson of Penn: "War does not so much produce social changes as hasten the fruition of those already in seed or bud, or again bring back to the light of day projects born years previously but later lost in the mists of inertia or political exigency."

What effect these reports will have on Canadian thinking and post-war developments, remain to be seen. We do know that the Beveridge Report has made a profound impression in Ottawa, and it is highly probable that the forthcoming session of parliament will give us a clear indication of the likely policies of the major political parties.

Hospital Plans Praised

(Continued from page 38)

In this connection, Paul V. McNutt, Director of the Defence of the United States, said to the hospital administrators of Canada and the United States, "An example of your co-operation is the rapid growth of non-profit community-sponsored hospital service plans. These plans now enable our ten millions to place hospital care in the family budget, along with other necessities. But I would like to suggest here that you consider the present membership as only the beginning of a movement concerned with the health of all the people in this country who need hospital care. Such a programme might well utilize whatever facilities of the Federal Social Insurance System may be necessary to accomplish the social ends."

"You will note that Mr. McNutt did not say that *government* would utilize the *plans* but that the *plans* might utilize the facilities of *government* to accomplish their social purposes. This is an enlightened viewpoint with which we are all in agreement.

"At this time and through this medium, I would like to congratulate Dr. J. J. Heagerty, Dominion Director of Public Health, on the important work he is doing to develop such a health plan for the people of the Dominion, and further I would like to offer to him and his associates the fullest co-operation of myself, the American Hospital Association, and the 76 approved Blue Cross Plans throughout this continent in the development of his project. I hope that he will regard this as no idle courtesy and that he will call upon me for any aid I may be able to give."

Price Trends

(On basis 1926 = 100)

	Yearly Average 1941	Nov. 1941	Oct. 1942	Nov. 1942
Building and Construction Material	107.3	112.1	116.2†	116.4
Consumers' Goods (Wholesale)	91.1	96.7	96.9	97.3
(On basis 1935-1939 = 100)				
Cost of Living	111.7	116.3	117.8	118.6

†Revised

(C. of L. for December, 1942, 118.8)

Hospitals Have Part in Public Health Programs

(Concluded from page 36)

terially to the improvement of the public health.

Hospital representatives should display a most active interest in local health conditions, and local health programmes. This may well be reflected in staunch support of the health department and other health agencies, if their programmes justify the same. We can do much by education and by the conduct of essential services to bring about a greater desire on the part of all for more vigorous physical and mental health.

Nuns May Take Over Hospital at Sarnia

It has been reported that the Sisters of St. Joseph are willing to take over the Sarnia General Hospital if the city agrees. The hospital is seriously overcrowded and badly needs another wing. However, a by-law to raise the necessary funds to build a $300,000 addition was turned down by the ratepayers at the annual election.

The hospital commission has been informed that the Sisters of St. Joseph are willing to purchase the local hospital and to build the required wing themselves. In referring the matter to the City Council the commission stated that it was not in favour of selling the hospital but that it had no objection to another hospital being erected.

Patients Unaware of Hospital Fire

Some damage was done to the auditorium of Christie Street Military Hospital in Toronto before a fire, believed to have been started deliverately, was brought under control by the city fire department. The suspect, one of the patients in the hospital, was remanded without arraignment, plea or election for mental examination.

The fire was discovered by a cleaner who happened to go into the auditorium and found the wall burning in five places. However, so quickly was the blaze put out that patients in the surrounding buildings were unaware of the disturbance. The auditorium is separated from the main hospital building by a distance of about one hundred feet.

The "Swap Column"

Have you anything that you would like to swap for something else? In these days when equipment is hard to obtain, it may just be that you have something for which you have no further use and which may be of value to another hospital which could dispose of equipment of value to you. On the suggestion of several people, "The Canadian Hospital" in our last issue set up a "swap column".

There will be no charge for the inclusion of any items in this column and it will be maintained as long as it serves any useful purpose to the hospital field. Both hospitals and supply houses are invited to send in offers and requests.

Name and address of hospital or advertiser must be given. Copy should reach the business office of "The Canadian Hospital", 57 Bloor St. West, Toronto, not later than the 25th of the month for the following month's issue.

Surgical Instruments for Sale, some practically new, including: 73 pairs Haemostats or artery forceps, standard types. 49 only, Bone instruments—including drills, trephines, elevators, curette gouges, chisels, cutting and holding forceps, etc. 31 only, Bone plates (Vanadium steel). 1 only, Sharp and Smith large bone drill with burrs and drills. 67 only, Gynecological instruments—including senacular and vallcella forceps, cerineum needles, spacular, Goodall Dilator, curettes, scissors. 1 only, Set Hegars. Hollow uterine dilator in metal case. 28 only, Urethral instruments: — including catheters, sounds, dilators, catheter holders, crystoscope, urethescope stone searcher, urethotome. 15 only, Nasal instruments —specular, dressing forceps, catheters, saws, snare, belocynes, canular. 25 only, Stomach, intertinal; Hysterectomy clamps (standard patterns). 8 only, Dressing and tissue forceps—short patterns. 7 only, Abdominal wound retractors—various types. 1 only, Balfour abdominal retractor. 1 only Welch Allyn opthalmascope — large handle (may have to be adjusted).

Many other items available. Complete list on application. St. John's Convalescent Hospital, Newtonbrook, Ont.

* * *

1 small size Incinerator used only three times. 1 Rudd Heater which is in good condition. Daughters of the Empire Hospital for Convalescent Children, 54 Sheldrake Blvd., Toronto.

* * *

I unused physician's register, 22½" x 50½", 54 name spaces, non illuminated, oak finish. The Public General Hospital, Chatham, Ont.

* * *

4 doz. New Wh.E. douche pans, similar to No. J/1012 (Hartz) at $18.00 a dozen, or would exchange for Wh. E. Perfection type Bed Pans. Royal Victoria Hospital, Montreal, Que.

* * *

1 McKesson Metabolor on portable stand, approximately 12 years old, needs repair to clock mechanism. The Nicholls Hospital, Peterborough, Ont.

* * *

For sale, a 3-section Prowse gas range with ovens and warming cabinets. One section has four open type burners, the other two sections have one closed type burner each with rings. The range is 8′ 5″ long, 3′ 6″ wide, 5′ 5″ high to the top of the warming cabinet. It was only in use a little over a year, and will be sold at a sacrifice price. Verdun Protestant Hospital, Post Office Box 6034, Montreal, Quebec.

Index of Advertisers

JANUARY, 1943

Good boots are essential to the comfort of our fighting forces. They cost $4.80. Twenty

War Savings Stamps

will buy the boots and a ball-bearing for a Valentine tank!